

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10782

787

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 37		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		(4 days)		d. STREET ADDRESS 306 Cannon Street		
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First IDA	Middle MAY	Last BRATCHER	4. DATE OF DEATH	Month January 4	Day Year 1958
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1902	9. AGE (In years <sup>last birthday</sup> yrs.) 55	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charlie Turner			14. MOTHER'S MAIDEN NAME Gertrude <del>REED</del> Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-12-4738		17. INFORMANT Address Hospital Records Chestertown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				Intracranial Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterial Hypertension						several years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 1, 1958, to January 4, 1957, that I last saw the deceased alive on January 5, 1958, and that death occurred at 11:55 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. W. Farr</i> M.D.						ADDRESS (Street, city or town, state) Chestertown, Maryland
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/58		22c. NAME OF CEMETERY OR CREMATORIUM Janes Cemetery		22d. LOCATION (City, town, or county) near - Chestertown, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth Walker</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 8 '58		24b. REGISTRAR'S SIGNATURE <i>Reed</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00783

## 797 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SASSAFRAS</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SASSAFRAS</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>PERRY</b>	Middle <b>HENRY</b>	Last <b>Brown</b>	4. DATE OF DEATH <b>JAN. 25 - 1958</b>	Month <b>JAN.</b>	Day <b>25</b>	Year <b>1958</b>	
5. SEX <b>M.</b>		6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 22, 1891</b>	9. AGE (In years less birthday) <b>66</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION Building</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>No.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>PERRY Brown</b>		14. MOTHER'S MAIDEN NAME <b>MARY WARNER</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>212-12-3757</b>		17. INFORMANT <b>GEORGIANA Brown, SASSAFRAS, Md.</b>		Address			
18. CAUSE OF DEATH. [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4222</b> DUE TO Terminal Pneumonia				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
		Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Myocardial Insufficiency & decomps (c)				1-2 weeks			
19. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No accident</b>							
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) <b>—</b>		(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>Jan 24, 1958</b> to <b>Jan 25, 1958</b> , that I last saw the deceased alive on <b>Jan 24, 1958</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>H.H. Hamilton</b>		ADDRESS (Street, city or town, state) <b>M.D.</b>				DATE SIGNED <b>1/27/58</b>			
PHYSICIAN'S NAME (Type) <b>H.H. HAMILTON</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/30/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>WESLEY HENRY CEM. GALT</b>		22d. LOCATION (City, town, or county) <b>Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		ADDRESS <b>Mellington, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Edward Fellows</b>			

THE STATE OF HAWAII - SALVATION ARMY

CERTIFICATE OF DEATH

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AN 31 1958

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00784

788

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains for prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Kent MARYLAND		a. STATE Maryland	b. COUNTY Kont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Chestertown		4 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Kent and Queen Anne Hospital		/d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Robert		Byard
4. DATE OF DEATH	Month	Day	Year
	January	29	19 58
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male	Col.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 30, 1930
9. AGE (in years at birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
27 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		11. BIRTHPLACE (State or foreign country)	
Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Phillip Byard		Mattie Goldsberry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
Hospital chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Concussion and shock</u> 5 hours			
DUE TO Deceased was attacked about 11:00 P.M. near his home			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>in Golts, Md. Brought to the Kent and Queen Anne Hosp.</u>			
DUE TO <u>in Chestertown 2:30 A.M. He was found to be suffering</u>			
(c) <u>from multiple lacerations of the head due to blows</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY with a club. He was severely shocked from exposure to cold and from YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> 1/28 1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Golts, Md.		Golts Kent Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that			
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE	DATE SIGNED		
Robert W. Farr	1/29/58		
EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Funeral	3/3/58	Valley Cem.	Middleton Del.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. RECD BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Edward Teller Millington Md.		FEB 7 1958	John E. Brown

BUREAU X-15

FEB 7 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1 798 CERTIFICATE OF DEATH

Reg. Dist. No.

110785

1. PLACE OF DEATH a. COUNTY <u>KENT</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u>		b. COUNTY <u>KENT</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CHARLES</u>		First <u>S.</u>	Middle <u>S.</u>	Last <u>CHURCH</u>	4. DATE OF DEATH	Month <u>JAN.</u>	Day <u>30</u>	Year <u>1958</u>
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 21, 1886</u>	9. AGE (in years, last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR OR UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-DISTRICT MAN. E. S. P. Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>E. S. P. Service</u>		11. BIRTHPLACE (State or foreign country) <u>BERGAN, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>GEORGE H. CHURCH</u>				14. MOTHER'S MAIDEN NAME <u>BELLE FARNHAM</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>22-03-8658</u>		17. INFORMANT <u>MRS. HELEN B. CHURCH, MILLINGTON</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> <i>Caervicomatosis</i>		3 years						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostatic Malignancy</u>		4 years						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>MILLINGTON</u>		(County) <u></u> (State) <u>MD.</u>
21. I certify that I attended the deceased from <u>Oct. 1, 1953</u> to <u>Jan. 30, 1958</u> , that I last saw the deceased alive on <u>Jan. 30, 1958</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>MILLINGTON, MD.</u>						
ACTUAL SIGNATURE <u>H. H. HAMILTON</u>		DATE SIGNED <u>1/31/58</u>						
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MILLINGTON CEM.</u>		22d. LOCATION (City, town, or county) <u>MILLINGTON</u>		(State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		ADDRESS <u>MILLINGTON, MD.</u>		24a. REC'D. BY REGISTRAR <u>FEB. 6</u>		24b. REGISTRAR'S SIGNATURE <u>John Smith</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AMERICAN STATE-OWNED AIRLINE - AIRLINES

CERTIFICATE OF DEATH

BUREAU X-14

FEB 6 1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Kent.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Galeva (Georgetown)</i>		c. LENGTH OF STAY IN 1b <i>Entire life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <i>Galeva (Georgetown)</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>WILLARD BORTON EDWARDS</i>		First <i>W</i>	Middle <i></i>
4. DATE OF DEATH <i>January 5 1958</i>		Last <i></i>	Month <i>January</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>Widowed</i> <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Dec 31, 1894</i>
9. AGE (In years from birth to death) <i>63 yrs.</i>		10. IF UNDER 1 YEAR Months <i></i> Days <i></i>	11. IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Budger buster</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Roads Bureau</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Edwards</i>		14. MOTHER'S MAIDEN NAME <i>Carrie King</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-22-3931</i>	
17. INFORMANT <i>Mrs. Gladys Stacy Edwards</i>		Address <i>Galeva Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Unknown, but probably cardiac.</i> DUE TO <i>Want to work 6 am 1/4/58. Last seen alive 8:30 am 1-4-58</i> 795.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Found dead 6 am 1/5/58</i> DUE TO <i></i> (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i></i> (State) <i></i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		DATE SIGNED <i>1/5/58</i>	
EXAMINER'S NAME (Type) <i>ROBERT W. FARR</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 8, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Massie Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Massie Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert W. Farr Millington Md.</i>		ADDRESS <i>Robert W. Farr Millington Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>Jan 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Robert W. Farr</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the remains or prior to burial, cremation, or removal.

BUREAU U. S.

IAN 13 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00788

789

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 34 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Ann's						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Thomas	Middle B	Last Elbourn	4. DATE OF DEATH January	Month 4	Day 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 27, 1902	9. AGE (In years last birthday) 55 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fishing, dock building		11. BIRTHPLACE (State or foreign country) Rock Hall, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Elbourn			14. MOTHER'S MAIDEN NAME Sara Kendall				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Ruptured aneurysm of abdominal aorta INTERVAL BETWEEN ONSET AND DEATH 36 hours							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerosis ?							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chestertown	(County)	(State)	
21. I certify that I attended the deceased from 1-2, 1958, to 1-4, 1958, that I last saw the deceased alive on 1-4, 1958, and that death occurred at 12:55a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Chestertown, Maryland DATE SIGNED 1-4-58							
ACTUAL SIGNATURE <i>A.C. Dick</i>							
PHYSICIAN'S NAME (Type) A.C. Dick							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/4/58	22c. NAME OF CEMETERY OR CREMATORIAL St. Paul	22d. LOCATION (City, town, or county) Chestertown, Maryland (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar J. Dick</i>				ADDRESS Chestertown, Maryland	24a. REC'D. BY REGISTRAR JAN 15 1958	24b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
the certificate should be detached from use as the burial-transit Permit. Then please remove carbon paper. Page 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

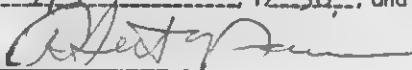
790

## CERTIFICATE OF DEATH

Reg. Dist. No.

00787

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be signed by the hospital or attending physician.  
 TO FULL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 Spring Ave.		d. STREET ADDRESS 110 Spring Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Marguerite	Middle Cree	Last Eli-son
4. DATE OF DEATH	Month Jan.	Day 5	Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 6 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Ft. McHenry, Balto., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John K. Cree		14. MOTHER'S MAIDEN NAME Agnes Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Thos. W. Eliason, Chestertown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable acute coronary insufficiency with a few minutes DUE TO pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis & aortic stenosis at least 6 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH utes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/19 1957, to 1/5 1958 that I last saw the deceased alive on 1/5 1958, and that death occurred at M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 1/6/58	
ACTUAL SIGNATURE 		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 7/58	22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery	22d. LOCATION (City, town, or county) Chestertown, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Marvin J. Williams— Chestertown, Md.		24a. REC'D BY REGISTRAR DATE 1/9 '58	
		24b. REGISTRAR'S SIGNATURE 	

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **00789**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRLEE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>JAMES</b>	Middle <b>FRANC</b>
4. DATE OF DEATH Month <b>JAN</b> Day <b>2</b> Year <b>1958</b>		5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 6, 1889	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. MOTHER'S MAIDEN NAME <b>Anna Venable</b>	
13. FATHER'S NAME <b>James Alfred French</b>		14. INFORMANT Address <b>Mrs. Mary Hatcherow, Chestertown, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-36-5446</b>	
17. INFORMANT Address <b>Mrs. Mary Hatcherow, Chestertown, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Natural causes, but unknown was,</b> DUE TO <b>Probably congestive heart failure</b> DUE TO <b>Don't know</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Was found dead in bed, he had a heart attack or died</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>1-1-58 last seen alive 11:30 AM</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>		DATE SIGNED <b>1/2/58</b>	
ACTUAL SIGNATURE <b>R. E. French</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>RUBERT W. FARR</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 4, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Paul Cem.</b>		22d. LOCATION (City, town, or county) <b>nr. - Chestertown, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Willis Wells</b>		24a. REC'D BY REGISTRAR <b>JAN 5 1958</b> DATE	
ADDRESS <b>Chestertown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>A. J. Reddick</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

791

## CERTIFICATE OF DEATH

00790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		b. COUNTY Kent	
c. LENGTH OF STAY IN lb 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		d. STREET ADDRESS RFD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Agnes	Middle Goldsborough	Last Jan 28 1958
4. DATE OF DEATH	Month Jan	Day 28	Year 1958
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1904 63 yrs.
9. AGE (In years last birthday) 63 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. KIND OF BUSINESS OR INDUSTRY Home	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Wright	14. MOTHER'S MAIDEN NAME Mary Thomas	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 220-32-7879		17. INFORMANT Hospital records	Address Chestertown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH 8-9 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arterial Hypertension</u>		Several years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>58</u> , alive on <u>1/28/58</u> , 19 <u>58</u> , and that death occurred at <u>4:40 P.M.</u>		to <u>1/28/58</u> , 19 <u>58</u> , that I last saw the deceased from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Robert W. Farr</i>		ADDRESS (Street, city or town, state) Chestertown, Md.	
PHYSICIAN'S NAME (Type) ROBERT W. FARR		DATE SIGNED 1/29/58	
22a. BURIAL, CREMATION, or other (Specify) Burial	22b. DATE THEREOF Feb. 1, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Broad Neck Cem.	22d. LOCATION (City, town, or county) near Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth Wallby</i>		24a. REC'D BY REGISTRAR DATE JAN 3 1958	24b. REGISTRAR'S SIGNATURE <i>Amesbury</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
it should be detached for use as the burial-transit permit. Then please remove carbon paper. Part 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00791

801

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond		c. LENGTH OF STAY IN 1b 70 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond		d. STREET ADDRESS —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Willis	Middle K.	Last Hackett	4. DATE OF DEATH	Month January	Day 25	Year 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 90	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
Male	White	WIDOWED <input checked="" type="checkbox"/>	Divorced <input type="checkbox"/>	June 15, 1867	90	90	90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cannery		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew J. Hackett				14. MOTHER'S MAIDEN NAME Mary Elizabeth Cavender			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		None		Mrs. E. K. Jones		Still Pond, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-23 1958, to 1-25 1958, that I last saw the deceased alive on 1-23-58 1958, and that death occurred at 3:00 a.m., from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. C. Dick</i>		ADDRESS (Street, city or town, state) Chestertown, Maryland					
PHYSICIAN'S NAME (Type) A. C. Dick		DATE SIGNED 1-25-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/58		22c. NAME OF CEMETERY OR CREMATORIY Still Pond Cemetery		22d. LOCATION (City, town, or county) Still Pond, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Victor N. Kennedy</i>		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR JAN 28 1958		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>KENT</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		c. LENGTH OF STAY IN 1b <b>3 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		d. STREET ADDRESS <b>1202 LYNCHBURG</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT &amp; QUEEN ANNE'S</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>DELIA</b>		First	Middle	Last	4. DATE OF DEATH <b>HOLLEY</b>	Month	Day	Year		
5. SEX <b>F</b>		6. COLOR OR RACE <b>COL.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <b>Mar. 3, 1910</b>	10. AGE (In years last birthday) <b>47</b>	11. IF UNDER 1 YEAR Months <b>0</b>	12. IF UNDER 24 HRS Days <b>0</b>	13. IF UNDER 24 HRS Hours <b>0</b>	14. IF UNDER 24 HRS Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>KENT, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>LEWIS HOLLEY</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE MITCHELL</b>				Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL CHART</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b>		DUE TO <b>UREMIA</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <b>RENAL ARTERIOSCLEROSIS</b>								
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>DIABETIC GANGRENE, LEG</b>								
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>CHESTERTOWN, Md</b> (State) <b>Md</b>				
21. I certify that I attended the deceased from <b>JAN 7</b> , 1958, to <b>JAN 7</b> , 1958, that I last saw the deceased alive on <b>JAN 7</b> , 1958, and that death occurred at <b>4 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHESTERTOWN, Md</b>						DATE SIGNED <b>1-7-58</b>				
MEDICAL CERTIFICATION SIGNATURE <b>C. T. Keefe</b>		M.D.								
PHYSICIAN'S NAME (Type) <b>A. T. KEEFE, JR. MD</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/9/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>James Cemetery</b>		22d. LOCATION (City, town, or county) <b>Year Chester, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Waller</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Keefe</b>				

Note Corrections made at Kent and Queen Anne's Hospital  
Record Room.

R. M. Bowes. M. R. C.

RECEIVED  
JAN 18 1944  
PURCHASE V. 2

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		b. COUNTY Kent	
c. LENGTH OF STAY IN 1b 55 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		d. STREET ADDRESS ---	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William James Hopkins		4. DATE OF DEATH Month Day Year January 10, 1958	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1877	
9. AGE (in years last birthday) 80 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Dots Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 213-22-8575	
17. INFORMANT Norman Hopkins		Address Kennedyville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/11, 1957, to 1/10, 1958, that I last saw the deceased alive on 1/10, 1958, and that death occurred at 6:58 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Chesterstown, Md.			
ACTUAL SIGNATURE Thomas Solon		DATE SIGNED 1/10/58	
PHYSICIAN'S NAME (Type) Thomas Solon		Chesterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/58	
22c. NAME OF CEMETERY OR CREMATORIAL Crumpton Cemetery		22d. LOCATION (City, town, or county) Crumpton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.	
24a. REC'D BY REGISTRAR DATE JAN 13 '58		24b. REGISTRAR'S SIGNATURE Reef Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

793

## CERTIFICATE OF DEATH

Reg. Dist. No.

110794

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent and Queen Ann</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lynch</b>					
f. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Lelia</b>	Middle <b>H.</b>	Last <b>Hossinger</b>				
4. DATE OF DEATH	Month <b>January</b>	Month <b>29</b>	Day <b>19</b>	Year <b>58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1866</b>	9. AGE (In years less birthday) <b>91</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis S. Hepburn</b>			14. MOTHER'S MAIDEN NAME <b>Mary E. Roseberry</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital records, Chestertown, Md.</b>			
Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Old age</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Jan. 15</b> , 1958, to <b>Jan. 29</b> , 1958, that I last saw the deceased alive on <b>Jan. 28</b> , 1958, and that death occurred at <b>10:15a</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE <i>A.C. Dick</i>							
DATE SIGNED <b>1-29-58</b>							
PHYSICIAN'S NAME (Type)		M.D. <b>Chestertown, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-1-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>STILL POND CEMTRY</b>		22d. LOCATION (City, town, or county) <b>STILL POND</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Victor N. Kennedy</i>			ADDRESS <b>STILL POND, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 31 '58</b>		24b. REGISTRAR'S SIGNATURE <i>John E. Kennedy</i>

BRITAIN A. S.

JAN 31 1958

REGD

REGD. 5-1-58. BRITISH CROWN  
PRINTED IN U.K. BY THE GOVERNMENT OF THE  
UNITED KINGDOM

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

803 CERTIFICATE OF DEATH				Reg. Dist. No. 00795
1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY KENT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETTERTON		c. LENGTH OF STAY IN lb 4 1/2 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BETTERTON		
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Florence First, Scoville Middle, Lloyd		4. DATE OF DEATH JAN Month 17 Day Year 1958		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 16, 1887	9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) CHICAGO, ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME AMASA U. Scoville		
14. MOTHER'S MAIDEN NAME MAY Williams		15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		
16. SOCIAL SECURITY NO. —		17. INFORMANT SHERMAN C Lloyd Sr.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CEREBRAL VASCULAR ACCIDENTS DUE TO (c) ARTERIO SCEROSIS		INTERVAL BETWEEN ONSET AND DEATH 5 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 17, 1958, to Jan 17, 1958, that I last saw the deceased alive on Jan 17, 1958, and that death occurred at 8:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED		
ACTUAL SIGNATURE Florence Deringer Joyce M.D.		WORTON, MD. Jan 17, 1958		
PHYSICIAN'S NAME (Type) FLORENCE DERINGER JOYCE		WORTON, MD.		
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-20-58		22c. NAME OF CEMETERY OR CREMATORIAL WILMINGBN & BRANDYWINE
22d. LOCATION (City, town, or county) WILMINGTON		(State) DEL.		
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS STILL POND, MD.		24a. REC'D BY REGISTRAR DATE JAN 20 '58
				24b. REGISTRAR'S SIGNATURE <i>W. Lee</i>

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501 502 503 504 505 506 507 508 509 509 510 511 512 513 514 515 516 517 518 519 519 520 521 522 523 524 525 526 527 528 529 529 530 531 532 533 534 535 536 537 538 539 539 540 541 542 543 544 545 546 547 548 549 549 550 551 552 553 554 555 556 557 558 559 559 560 561 562 563 564 565 566 567 568 569 569 570 571 572 573 574 575 576 577 578 579 579 580 581 582 583 584 585 586 587 588 589 589 590 591 592 593 594 595 596 597 598 599 599 600 601 602 603 604 605 606 607 608 609 609 610 611 612 613 614 615 616 617 618 619 619 620 621 622 623 624 625 626 627 628 629 629 630 631 632 633 634 635 636 637 638 639 639 640 641 642 643 644 645 646 647 648 649 649 650 651 652 653 654 655 656 657 658 659 659 660 661 662 663 664 665 666 667 668 669 669 670 671 672 673 674 675 676 677 678 679 679 680 681 682 683 684 685 686 687 688 689 689 690 691 692 693 694 695 696 697 698 699 699 700 701 702 703 704 705 706 707 708 709 709 710 711 712 713 714 715 716 717 718 719 719 720 721 722 723 724 725 726 727 728 729 729 730 731 732 733 734 735 736 737 738 739 739 740 741 742 743 744 745 746 747 748 749 749 750 751 752 753 754 755 756 757 758 759 759 760 761 762 763 764 765 766 767 768 769 769 770 771 772 773 774 775 776 777 778 779 779 780 781 782 783 784 785 786 787 788 789 789 790 791 792 793 794 795 796 797 798 799 799 800 801 802 803 804 805 806 807 808 809 809 810 811 812 813 814 815 816 817 818 819 819 820 821 822 823 824 825 826 827 828 829 829 830 831 832 833 834 835 836 837 838 839 839 840 841 842 843 844 845 846 847 848 849 849 850 851 852 853 854 855 856 857 858 859 859 860 861 862 863 864 865 866 867 868 869 869 870 871 872 873 874 875 876 877 878 879 879 880 881 882 883 884 885 886 887 888 889 889 890 891 892 893 894 895 896 897 898 899 899 900 901 902 903 904 905 906 907 908 909 909 910 911 912 913 914 915 916 917 918 919 919 920 921 922 923 924 925 926 927 928 929 929 930 931 932 933 934 935 936 937 938 939 939 940 941 942 943 944 945 946 947 948 949 949 950 951 952 953 954 955 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1874 1875 1876 1877 1878 1879 1879 1880 1881 1882 1883 1884 1885 1886 1887 1888 1889 1889 1890 1891 1892 1893 1894 1895 1896 1897 1898 1899 1899 1900 1901 1902 1903 1904 1905 1906 1907 1908 1909 1909 1910 1911 1912 1913 1914 1915 1916 1917 1918 1919 1919 1920 1921 1922 1923 1924 1925 1926 1927 1928 1929 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1939 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2419 2420 2421 2			

DATE 01/05/2016 BY 2016-05-01 16:00:00  
GILBERTS AVOCET 60013122 242  
U.S. FISH AND WILDLIFE SERVICE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00796

794

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		b. COUNTY Kent	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) Abbie First Estella Middle Quinn		4. DATE OF DEATH Jan. 19, 1958	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 2, 1876	
WIDOW <input checked="" type="checkbox"/>		9. AGE (In years at birthday) 81 yrs.	
DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Queen Anne Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? Maryland			
13. FATHER'S NAME Joseph Loller		14. MOTHER'S MAIDEN NAME Kathryn Pardee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, no unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Mary Bonwill		Address Still Pond, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Culmonary Delirium	
DUE TO (b)		Hypertension- Cardiovascular	
DUE TO (c)		Arterio Sclerosis	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 - 1957 to Jan 19, 1958, that I last saw the deceased alive on Jan 19, 1958, and that death occurred at 11:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Roxie Hall Newland	
ACTUAL SIGNATURE Heribert E. Stucky		DATE SIGNED 1958	
PHYSICIAN'S NAME (Type) NORBERT E. STUCKY			
22a. BURIAL, CREMATION, BUTTIAL (Specify) Jan. 21, 1958		22b. DATE THEREOF Jan. 21, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR DATE JAN 21 1958	
		24b. REGISTRAR'S SIGNATURE J. Willis Wells	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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REGULATED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

804

## CERTIFICATE OF DEATH

00797

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
int alton		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LINDA	Middle M.
4. DATE OF DEATH		last SMITH	Month Jan.
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housework		own Home	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? Phila. Pa. USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Samuel L Hoover		Zelia McCurdy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
none		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Breast Carcinoma (rt Breast) DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH 6 mos.		3 years.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) massive pleural effusion secondary to above.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15, 1957, to Jan 26, 1958, that I last saw the deceased alive on Jan 26, 1958, and that death occurred at 12:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE WALLACE OBENSHAUN M.D.		DATE SIGNED 27 Jan 58.	
PHYSICIAN'S NAME (Type) WALLACE OBENSHAUN		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 28 1958	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL Cecilton Cem.	
22d. LOCATION (City, town, or county) Cecilton, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Edward Waller Millington, Md.	
ADDRESS		24a. REC'D BY REGISTRAR JAN 3 1958	
		24b. REGISTRAR'S SIGNATURE Obenhausen	

BUREAU X. E.  
RECEIVED  
JAN 31 1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00798

805

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town		c. LENGTH OF STAY IN 1b 16 days	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 16 Hawthorne Ave;	
		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Lillian	Middle Smith
4. DATE OF DEATH Jan.	Month Jan.	Day 11	Year 19 19
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1926
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert L. Smith		14. MOTHER'S MAIDEN NAME Lillian	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT M. Smith--Rock Hall, Maryland
18. CAUSE OF DEATH [Enter only one cause per line to (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cardio Vasculas (c) DUE TO Cerebral Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>Jan 4, 1958</u> , that I last saw the deceased alive on <u>Jan 4, 1958</u> , and that death occurred at <u>Rock Hall</u> , M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Rock Hall DATE SIGNED Robert C. Kitch	
ACTUAL SIGNATURE ROBERT C. KITCH		PHYSICIAN'S NAME (Type) ROBERT C. KITCH	
22a. BURIAL, CREMATION, REMOVAL (Specify) T. C. C. 1958		22b. DATE THEREOF 1958	
22c. NAME OF CEMETERY OR CREMATORIAL In. C. I. C. 1958		22d. LOCATION (City, town, or county) T. C. C. 1958	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS T. C. C. 1958	
24a. REC'D BY REGISTRAR JAN 20 '58		24b. REGISTRAR'S SIGNATURE Albert	

YANKEE'S

EGG . . . N.Y.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

806

## CERTIFICATE OF DEATH

00799

Reg. Dist. No.

**NOTICE TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely executed in by the funeral director, Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town near Chestertown		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kennebunkville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) Flora Bell: Bourne		4. DATE OF DEATH J 1, 1958	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M	6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30. 12. 1877			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Baltimore; Green Ind.			
13. FATHER'S NAME Sanford Reynolds		14. MOTHER'S MAIDEN NAME Mabel				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 123-12-1212	17. INFORMANT Mrs. . . . . BlackKen edville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC HT. DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>SENILITY</u>						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from <u>2/7</u> , 1958, to <u>1/26</u> , 1958, that I last saw the deceased alive on <u>1/17</u> , 1958, and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Joseph A. Elliott</i>	ADDRESS (Street, city or town, state) M.D. <u>West St. Laurel Del.</u>			DATE SIGNED <u>1/26/58</u>		
PHYSICIAN'S NAME (Type) <i>JOSEPH A. Elliott</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/28/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul Cemetery	22d. LOCATION (City, town, or country) Near Fairlee, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.		ADDRESS	24a. REC'D BY REGISTRAR JAN 22 1958	24b. REGISTRAR'S SIGNATURE <i>John J. Williams</i>		

BUREAU Y. E.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 807 CERTIFICATE OF DEATH

Reg. Dist. No. 100800

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton		c. LENGTH OF STAY IN 1b 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Betterton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First John	Middle C.	Surname Sutton	4. DATE OF DEATH January 4, 1958	Month January	Day 4	Year 1958
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1861	9. AGE (in years last birthday) 93 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME John Carvel Sutton	14. MOTHER'S MAIDEN NAME Caroline Spencer
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Arthur G. Sutton, Chester, Pa.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos.
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PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1958, to Jan 4, 1958, that I last saw the deceased alive on Jan 4, 1958, and that death occurred at 6:30 P.M., from the causes and on the date stated above		ADDRESS (Street, city or town, state)	DATE SIGNED 4 Jan 58
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ACTUAL SIGNATURE Wallace Obenshain	M.D.	Cecilton, id.
PHYSICIAN'S NAME (Type) WALLACE OBENSHAIN		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/6/58	22c. NAME OF CEMETERY OR CREMATORIAL Shrewsbury Cemetery	22d. LOCATION (City, town or county) Kennedyville, id.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy	ADDRESS Still Pond, id.	24a. REC'D BY REGISTRAR DATE JAN 8 '58	24b. REGISTRAR'S SIGNATURE W. L. French
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000 ft. 1000 ft.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**808 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 10801

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only 1 day is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b several years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Rock Hall				Rock Hall			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First John	Middle Nelson	Last Uriel	4. DATE OF DEATH Jan. 29	Month Day	Year 1958
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1899 May 9, 1900	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Balto. Fire Dept.		11. BIRTHPLACE (State or foreign country) XXXX Rock Hall, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Uriel		14. MOTHER'S MAIDEN NAME Anna Downey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Lawrence Uriel, Rock Hall, Md. (brother)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown but probable heart attack very short							
DUE TO Went to his room for the night 1/28/58 at 10:00P.M.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Found dead in the floor at the foot of his bed 8:00A.M.							
DUE TO 1/29/58. Has always been in good health and was apparently well when he retired. Has had no pain in chest							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) shortness of breath or indigestion. Rigormortis was complete							
20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20e. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20h. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED 1/29/58							
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb. 1		22c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel		22d. LOCATION (City, town, or county) Rock Hall (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane Church Hill, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR FEB 4 '58		24b. REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10802

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Queen Anne</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Hill</b>		d. STREET ADDRESS <b>1782</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ESTELLE</b>		First	Middle	Last	4. DATE OF DEATH <b>January</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>September 4, 1875</b>	9. AGE (In years lost birthday) <b>82</b> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY/ <b>USA</b>		
13. FATHER'S NAME <b>Samuel C Walls</b>			14. MOTHER'S MAIDEN NAME <b>Mary Rigby</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Hospital records, Chestertown, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
448X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) <b>Arterial Hypertension, &amp; Hypertensive cardio- vascular Disease</b>				Many years		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from January 1, 1958, and that death occurred at 10:35A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)						
ACTUAL SIGNATURE <i>Robert W. Farr</i>		DATE SIGNED Chestertown, Maryland Jan 1, 1958						
PHYSICIAN'S NAME (Type) <b>ROBERT W. FARR</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>JAN 3</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Church Hill</b>		22d. LOCATION (City, town, or county) <b>Church Hill Ind.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>		ADDRESS <b>Church Hill</b>		24a. REC'D BY REGISTRAR <b>1958</b>		24b. REGISTRAR'S SIGNATURE <b>A. Wadley</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

COMMONWEALTH OF MASSACHUSETTS  
DEPARTMENT OF PUBLIC SAFETY

COMMONWEALTH OF MASSACHUSETTS

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

796

## CERTIFICATE OF DEATH

Reg. Dist. No.

00803

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Frank	Middle Zungaila	Last Lithuanian	4. DATE OF DEATH January 10	Month 19	Day 58
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1893	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) mania Lithuanian		12. CITIZEN OF WHAT COUNTRY? Don't know	
13. FATHER'S NAME John Zungaila		14. MOTHER'S MAIDEN NAME Catherine Martinkis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Don't know		16. SOCIAL SECURITY NO. Don't know		17. INFORMANT Hospital Records, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 433.1		2. CONGESTIVE HEART FAILURE & BRONCHOPNEUMONIA		3. DUE TO Auricular Fibrillation & Probable Exposure		4. INTERVAL BETWEEN ONSET & DEATH 10 days	
Conditions, if any, which goe rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from alive on		Jan. 5, 1958, to Jan. 10, 1958, that I last saw the deceased January 10, 1958, and that death occurred at 6:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chestertown, Md.		DATE SIGNED 1/10/58	
ACTUAL SIGNATURE Robert W. Farr, M.D.							
PHYSICIAN'S NAME (Type) Robert W. Farr, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 13, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cem.		22d. LOCATION (City, town, or county) Rock Hall, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR JAN 13 '58		24b. REGISTRAR'S SIGNATURE Albert L. Schuch	

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